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No. 85-225

Supreme Court, U.S.
FILED
DEC 3 1985
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JOINT APPENDIX

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PETITION FOR WRIT OF CERTIORARI FILED AUGUST 9, 1985
CERTIORARI GRANTED OCTOBER 7, 1985

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN

Civil Action No. 76-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND DAVID MATHEWS, SECRETARY OF HEALTH, EDUCATION AND WELFARE

RELEVANT DOCKET ENTRIES

Date	NR.	Proceedings
10/ 8/76	1.	Complaint, filed. – summons issued.
1/17/77	4.	ANSWER of Blue Cross and Blue Shield of Mi., only w/ special aff. defense and proof of service. Dd 1/17/77
1/18/77		Exhibit A. (attach tc #4) DD 1/18/77
4/ 1/77	5	ANSWER of HEW w/ cert. of service. DD 4/4/77
4/20/77	7.	Interr. Directed to Deft. Joseph Califano of HEW w/ proof of service. DD 4/20/77
6/30/77	10.	Deft's Motion to Dismiss w/ brief, cert. of service and notice of hrg. set for Aug. 26, 1977 @ 10:00 am. DD 7/1/77
8/30/77	14.	Supp. Interr. to Blue Cross and Blue Shield of Michigan. DD 8/30/77
9/26/77	16.	Deft's Answer to Pltf's First Set of interr. w/ attachments A-H. DD 9/27/77

10/ 5/77	17.	Request for response on motion to dismiss by Deft. HEW, all responses, reply briefs, and any supp. briefs by Dec. 5, 1977; hrg. set for Dec. 16, 1977 @ 2:30pm. DD 10/6/77
10/26/77	18.	Answers of Defendant, Blue Cross and Blue Shield of Michigan to Plaintiffs' supplemental interrogatories. DD 10/27/77.
10/26/77	19.	Defendants' Supplemental Answer to Plaintiffs' First Set of Interrogatories with attachments and certificate of service. DD 10/27/77.
11/30/77	21.	Answer by ptfs to defts' motion to dismiss with brief and proof of service. DD 12/1/77.
12/ 7/77	22.	Defts' 2nd supplemental answer to ptfs' 1st set of interrogatories attachments DD 12/7/77
12/16/77	23.	Motion to Dismiss, taken under advisement.
12/28/77	23.	MEMORANDUM OPINION that Deft. Sec's. motion to dismiss the complaint as to any party will be denied. DD 12/30/77 Churchill J.
12/28/77	24.	ORDER Denying Deft's Motion to Dismiss. DD 12/30/77 Churchill J.
3/27/78	27.	Deposition of Paul Riesel. DD 3/29/78
4/ 5/78	30.	Plaintiff's motion for production of documents with brief, exhibits and proof of service. Hearing April 21/78. DD 4/6/78.
4/21/78	33.	Depositions of Thomas M. Tierney. DD 4/24/78
4/21/78	34.	Deposition of Thomas Tierney. DD 4/24/78
4/24/78	35.	Deposition of James Barnett. DD 4/25/78
4/24/78	36.	Deposition of John Jansak. DD 4/25/78
4/21/78		Motion for production of documents granted with a protective order. DD 4/26/78

5/22/78	37.	Transcript of April 21, 1978. DD 5/23/78
6/ 7/78	38.	DEPOSITIONS of Helen Lazenby, Stanley Katz, Roger O. Egeberg, M.D. and Henry J. Hehir. DD 6/7/78
6/ 7/78	39.	DEPOSITIONS of Mildred L. Tyssowski, Lamont W. Williamson, Ann Gonzales and Stanley Katz. DD 6/7/78
6/19/78	40.	ORDER for Production of Documents and Protective Order. DD 6/22/78 Churchill J.
7/10/78	44.	Pltf's Supp. Interr. to Blue Cross and Blue Shield of Michigan w/proof of service. DD 7/12/78
8/15/78	45.	Deft. Blue Cross and Blue Shield of Michigan's Answers to Interr. w/exhibits, attached. DD 8/16/78
10/11/78	46.	Order of Re-Assignment to Judge Boyle. DD 10/13/78 Churchill J.
10/25/78	48.	Deposition of Robert Spain and Charles Hazelett, taken Aug. 22, 1978. DD 10/26/78
1/ 3/79		Status Conference Had; summary report due 3-27-79. DD 1/4/79 Cook, J.
1/25/79	55.	Deposition of Arthur D. Hamelin taken on 10-24-78. DD 1/26/79
1/25/79	56.	Deposition of Arthur J. Divak taken on 10-24-78. DD 1-26-79
1/25/79	57.	Depostition of Ronald Thomas Candelori taken on 10-23-78. DD 1-26-79
2/21/79	58.	Deposition of David Segal to be taken on 2-16-79 at 1:15 pm. DD 2-22-79
3/27/79		Status Conference had; Status Report due 5-29-79 at 4:45. Cook, J. DD 3-28-79

3/29/79	62.	Discovery Stipulation by the Parties. DD 3-29-79
4/27/79	64.	Answer to Amended Complaint DD 5-01-79
5/ 8/79	66.	Order that Pltf, Michigan Academy of Family Physicians, Charles Farber, M.D., Glenn W. House, M.D., and Lester Webb, M.D. are Granted leave to file a first amended complaint Cook, J. DD 5-11-79
5/31/79	67.	Order For Dismissal Blue Cross Blue Shield of Michigan in its private insurance capacity only without prejudice and without costs; so stipulated. Cook, J. DD 6-04-79
6/ 1/79	68.	Stip. and Order Granting Leave for Pltf to file First Amended Complaint, with First Amended Complaint attached. DD 6-04-79
6/21/79	71.	Deposition of Dennis Remington taken on 4-12-79. DD 6-22-79
6/22/79	72.	Deposition of William W. Boyles taken on 1-22-79. DD 6-25-79
6/22/79	73.	Depositions of David Siegel and Clara Thompson taken on 2-15-79 and 4-27-79. DD 6-25-79
1/15/80	77.	Stip. & Order allowing pltfs' to file second amended complaint. Cook, J. DD 1/21/80
1/15/80	78.	Pltfs' second amended complaint. DD 1/21/80
2/ 6/80	79.	Interrogatories propounded by defts' to pltfs' with proof of service DD 2/7/80
2/20/80	80.	Interrogatories to defts' with proof of service. DD 2/20/80
2/21/80	81.	Pltf's answers to interrogatories propounded by defts' to pltf's with affidavit, proof of service and attachments. DD 2/25/80

4/17/80	82.	Deposition of Ira Burney taken on 5/16/79. DD 4/17/80
4/17/80	83.	Deposition of E. Harvey Estes, Dr. M.D. taken on 12/14/79. DD 4/17/80
4/17/80	84.	Deposition of Irvin Robinson, Charles Fisher, Mahadev Mahabal and William J. Sobaski taken on 12/6/78. DD 4/17/80
4/17/80	85.	Deposition of Kenneth Kelley taken on 6/29/79. DD 4/17/80
4/17/80	86.	Deposition of George Schieber taken on 5/15/79. DD 4/17/80
4/17/80	87.	Deposition of Louis F. Hayes, M.D. taken on 11/6/78. DD 4/17/80
5/ 2/80	88.	Deft's answer to pltfs' second amended complaint
7/ 3/80	92.	Deposition of Carol A. Diedrich taken on 6/18/80. DD 7/3/80
7/10/80	93.	Order of reassignment to Judge Gilmore. Feikens, J. DD 7/28/80
9/ 2/80		Status conference held, matter set for non-jury trial on 9/11/80 at 9:00. Gilmore, J. DD 9/4/80
9/ 8/80	97.	Deposition of Robert L. Vitu, M.D. taken on 9/3/80. DD 9/8/80
9/16/80		Court continues to hear testimony, adj. to 9/17/80 at 9:00 Gilmore, J. DD 9/18/80
9/17/80		Testimony heard, trial adj. to 9/26/80 at 9:00 briefs due by 10/10/80 arguments set for 10/22/80 at 2:30. DD 9/18/80 Gilmore, J.
9/15/80		Court hears testimony in part on non-jury trial beginning today trial recessed to 9/16/80. Gilmore, J. DD 9/19/80

9/22/80	99.	Defts' motion to amend final pre-trial order to add expert witness with brief, proof of service, attachments and notice of hearing date to be set. DD 9/23/80
9/25/80	101.	Pltf's answer to defts' motion to amend final pre-trial order to add expert witness with brief and proof of service. DD 9/26/80
9/26/80		Court hears conclusion of testimony, matter set for arguments on 10/9/80 at 2:00. DD 10/1/80 Gilmore, J.
10/29/80		Final arguments heard & matter taken under advisement. Gilmore, J. DD 11/5/80
12/30/80	106.	Opinion by Judge Horace W. Gilmore that a judgment may be entered in accordance with this opinion, which shall constitute the findings of fact & conclusions of law required by FRCP 52. DD 12/31/80 Gilmore, J
1/21/81	107.	Defts' motions for rehearing and stay pending appeal with brief and proof of service. DD 1/21/81
1/22/81	108.	Pltfs' response to defts' motions for rehearing and stay pending appeal with proof of service. DD 1/23/81
1/23/81	109.	Judgment re: SEE JUDGMENT FOR ALL DETAILS. DD 1/26/81 Gilmore, J.
1/23/81		Hearing held Judgment entered. Gilmore, J. DD 1/29/81
2/23/81	111.	Order denying defts motion for rehearing & motion for stay pending appeal also denied. DD 3/10/81 Gilmore, J.
3/23/81	112.	Notice of appeal by Deft. DD 3/31/81
4/17/81	120.	Acknowledgment from CCA re: received notice of appeal on 4/3/81, Appeal case #81-1202. DD 4/21/81

1/25/82	127.	FILE with Transmittal to CCA. DD 1/25/82
2/10/82	128.	ACKNOWLEDGMENT of CCA re: receipt of file & supplemental transcripts. DD 2/11/82
7/26/82		TRANSMITTAL of supplemental transcripts (5 vol.) to CCA. DD 7/26/82
8/ 4/82	134.	CCA's Acknowledgment of receipt of supplemental transcripts. DD 8/ /82
2/11/83	135.	LETTER from dft HHS requesting attached exhibits be forwarded to CCA, with attachments. DD 2/11/83
2/11/83	136.	TRANSMITTAL with supplemental exhibits to CCA. Cert. #5297032. DD 2/11/83

IN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.
PLAINTIFFS-APPELLEES

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND PATRICIA HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES

RELEVANT DOCKET ENTRIES

Date		Filings – Proceedings
4/03/81	1.	Copy of notice of appeal filed; and cause docketed
1/28/82		*Certified Record* (4 vol. pleadings, 3 vol. transcript, 14 vol. depositions) filed
3/23/82	10.	Order granting appellants' motion to hold briefing in abeyance pending Supreme Court's decision in *United States v Erika, Inc.*, appellants shall file status reports at thirty (30) day intervals commencing 4/1/82.
7/30/82		*Certified Supplemental Record* (5 vol. transcript) filed
2/15/83		*Certified Supplemental Record* (1 vol. pleadings) filed
3/11/83		Joint Appendix (5) in 3 vols. (m-3/3/83)
8/29/83		Cause argued by Thomas Stuber for appellant; by Alan Gilchrist for appellee and case submitted to the Court (before: Jones, Peck, and Brown, JJ.)
2/23/84		Judgment remanding case to the Secretary for proceedings not inconsistent with this opinion (EACH PARTY TO BEAR OWN COSTS) (Jones, Peck and Brown, JJ.) F.P.

2/23/84		Opinion by Peck, J.
4/24/84	30.	Mandate issued (COSTS NONE)
7/30/84	31.	Notice of filing petition of Certiorari (Supreme Court No. 84-120) July 23, 1984.
10/ 1/84	32.	Certified copy of Supreme Court order granting petition for Writ of Certiorari; judgment vacated and case remanded to Sixth circuit for further consideration in light of *Heckler v. Ringer*
11/ 5/84	35.	Order remanding appeal to district court with instructions to dismiss (Jones, Peck and Brown, JJ.) NFP
11/15/84	36.	Petition for Rehearing (4) of appellee on 11/5/84 order (m-11/13/84)
1/28/85	40.	RESPONSE/APPELLANT: to appellee petition for rehearing (m-1/25)
2/20/85	41.	MOTION/APPELLEES: request permission to file response to appellant memorandum (m-2/14)
3/19/85	42.	PRINTED PUBLISHED ORDER granting petition for rehearing and rescinding order remanding cause to district court with instructions to dismiss; opinion of 2/23/84 is reaffirmed (Jones, Peck and Brown, JJ.)
4/01/85	43.	MOTION/APPELLANT: thirty days extension to file Petition for Rehearing EnBanc (m-3/29) (Extension to 5/2 granted; PECK, J.)
5/01/85	45.	PETITION FOR REHEARING ENBANC (m-4/30)
5/30/85	46.	ORDER: petition for rehearing en banc denied (Jones, Peck and Brown, JJ.)
6/07/85		MANDATE: issued
7/09/85	47.	MANDATE, reissued (No costs taxed)
8/20/85		SUPREME COURT NOTICE: petition for cert. filed 8/9/85 (Sup. Ct. No. 85-225)
10/23/85		SUPREME COURT ORDER: cert. granted 10/7/85
10/23/85		SERVICE OF Certified copy of Supreme Ct. ruling to Dist. Ct.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 76-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS; CHARLES FARBER, M.D.; BLENN W. HOUSE, M.D.; AND LESTER WEBB, M.D.,
PLAINTIFFS,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN; AND JOSEPH CALIFANO, SECRETARY OF HEALTH, EDUCATION AND WELFARE,
DEFENDANTS.

MEMORANDUM OPINION

This complaint, filed on October 8, 1976, challenges the administration of the federal Medicare program in Michigan by Blue Cross and Blue Shield of Michigan, especially as regards the classification of family practice physicians who are board eligible but not board certified. The Secretary filed a motion to dismiss the complaint for lack of subject matter jurisdiction on June 30, 1977. Oral argument was heard on December 16, 1977, and the matter was taken under advisement.

I am most impressed with, and adopt by reference, the analysis of the jurisdictional issue in *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283 (8th Cir. 1976).*

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* In arriving at the conclusion that the Eighth Circuit was correct, I am influenced by the improbability that Congress would intentionally authorize an administrative agency to delegate to a private contractor the power to violate the Constitution of the United States in the name of the United States without recourse.

Therein, in part V of its opinion, at p. 293, the court expressly declined to take a final position with respect to its jurisdiction to entertain the equal protection claim, stating:

> "Much of our jurisdictional analysis of the procedural due process issue presented in count II would seem to support our jurisdiction of count III, which also arises under the due process guaranty of the fifth amendment. If § 405(h) bars our jurisdiction, the University will have no judicial forum in which to assert its constitutional right to equal protection.
> "On the other hand, the direct purpose of this claim is to increase the amount of reimbursement to the University. Thus, it appears to fall squarely within the language of § 405(h) and of the Supreme Court in *Salfi*. 422 U.S. at 760-62, 95 S.Ct. at 2464-2465. 45 L.Ed.2d at 536-537. Additionally, count III seeks a money judgment against the United States. The doctrine of sovereign immunity probably would limit the Congress to force such an action even if based upon a constitutional violation. See *Dugan v. Rank*, 372 U.S. 609, 620, 83 S.Ct. 999, 1006, 10 L.Ed.2d 15, 23 (1983); *cf. Edelman v. Jordan*, 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974)."

The court was concerned that the direct purpose of the asserted claim was to increase the amount of reimbursement to the university. Without doubt the plaintiffs here are motivated in part by a desire for increased payment for services, but a judicial determination that the established screens are violative of equal protection will not necessarily, and as a matter of law, have that result.

It is clear from the record that there are disputed issues of fact which may control the Court's determination with respect to the rationality of the adopted classifications.

For the foregoing reason the defendant Secretary's motion to dismiss the complaint as to any party will be denied.

JAMES P. CHURCHILL
United States District Judge

Dated: December 28, 1977

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Civil No. 76-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS; CHARLES FARBER, M.D.; BLENN W. HOUSE, M.D.; AND LESTER WEBB, M.D., PLAINTIFFS

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN; AND JOSEPH CALIFANO, SECRETARY OF HEALTH, EDUCATION AND WELFARE, DEFENDANTS.

ORDER

DENYING DEFENDANT'S MOTION TO DISMISS

At a session of said court held in the Federal Building and U.S. Courthouse, Detroit, Michigan, on December 28, 1977.

Present: HONORABLE JAMES P. CHURCHILL
United States District Judge

For the reason set forth in a Memorandum Opinion bearing this date, IT IS ORDERED that the motion to dismiss filed by the Secretary of Health, Education and Welfare, on his behalf and as agent for Blue Cross and Blue Shield of Michigan, be and hereby is DENIED.

/s/ James P. Churchill

JAMES P. CHURCHILL
United States District Judge

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 6-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, A NON-PROFIT ASSOCIATION, CHARLES FARBER, M.D., GLENN W. HOUSE, M.D., AND LESTER WEBB, M.D., PLAINTIFFS,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, AND JOSEPH CALIFANO, SECRETARY OF HEALTH, EDUCATION AND WELFARE, DEFENDANTS.

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ATTORNEY FOR PLAINTIFFS

MICHELE COLEMAN MAYES – P25058
ATTORNEY FOR DEFENDANT HEW

RALPH D. GILPIN – P26273
ATTORNEY FOR DEFENDANT BCBSM

JUDGE JULIAN A. COOK

AMENDED COMPLAINT

NOW COME the plaintiffs, Michigan Academy of Family Physicians, a Non-Profit Association, Charles Farber, M.D. and Glenn W. House, M.D. and Lester Webb, M.D., by their Attorneys, FRIMET, GOREN & BELLAMY, P.C., and for their Amended Complaint state as follows:

JURISDICTION AND PARTIES

1. Jurisdiction herein is based upon 28 U.S.C. 1343, 5 U.S.C. 701, 702, 28 U.S.C. 1331, 42 U.S.C. 405(g) and 42 U.S.C. 405(h).

2. Plaintiff, Lester Webb, M.D., is a licensed family physician in the State of Michigan, being duly licensed to engage in the practice of medicine, whose residence is in the City of Saginaw, County of Saginaw, State of Michigan. Dr. Webb is a board eligible specialist in family practice who has no assignment agreement with defendants for purposes of reimbursement.

3. That Glenn W. House, M.D., is a licensed family physician, licensed to practice medicine in the state of Michigan whose residence is in the City of Greenville, County of Montcalm, State of Michigan. Dr. House is a board certified specialist in family practice who accepts assignment for purposes of Medicare reimbursement.

4. Charles Farber, M.D., is a licensed family physician, licensed to practice medicine in the State of Michigan whose residence is in the City of Grand Rapids, County of Kent, State of Michigan. Dr. Farber is a board eligible specialist in family practice accepting assignment for purposes of Medicare reimbursement.

5. Plaintiff, Michigan Academy of Family Physicians, is a non-profit association consisting of approximately 1,500 family physicians (i.e., physicians educated and trained to develop, bring to bear and practice unique attitudes and skills which qualify him or her to provide continuing, comprehensive health maintenance medical care to the entire family, regardless of age, sex or type of problem, be it biological, behavioral, or social) throughout the state of Michigan, and whose principal place of business is in the City of Plymouth, County of Wayne, State of Michigan.

6. That the membership of the Michigan Academy of Family Physicians consists of board certified, board eligible and non-board eligible family practitioners in the state of Michigan.

7. Plaintiff, the Michigan Academy of Family Physicians, is an organization interested in alleviating the present shortage of primary care physicians and, to this end, encourages individuals entering the medical field to specialize in primary care.

8. Pursuant to statutory authority under the Social Security Act, the Secretary of Health, Education and Welfare Medicare Program. One of the regulations issued by the Secretary states that the Secretary is designated as the real party in interest in administration of the program. 33 Federal Register 11274 (Aug. 8, 1968).

9. Defendant, Joseph Califano, is a real party in interest in the administration of the Medicare Program.

10. Defendant Blue Cross and Blue Shield of Michigan (hereinafter referred to as BCBSM) is a Medical Care Corporation organized and operated under the Blue Shield Act, MCLA 550.301 et seq., and is a Hospital Care Corporation, organized and operated under the Blue Cross Act, MCLA 550.501 et seq with its principal offices at 600 Lafayette East, City of Detroit, County of Wayne, State of Michigan.

11. As a Medical and Hospital Care Corporation, defendant BCBSM offers various extensive health insurance programs to the general public. The Department of Health, Education and Welfare has designated BCBSM as the fiscal carrier under the Medicare Program for the state of Michigan.

12. That as the fiscal carrier under the Medicare Program for the state of Michigan, BCBSM processes claims submitted by physicians for services performed on behalf of Medicare recipients and generally administers the day to day operations of the Medicare Program as that program relates to the state of Michigan.

BACKGROUND FACTS

13. That in 1965 Congress enacted Title XVIII of the Social Security Act (Medicare) 42 U.S.C. 1395 et seq. This Act provides for Federal reimbursement for medical care to the aged.

14. That the Medicare Statute is divided into two distinct and separate parts; Part A involves institutional care, hospitals, nursing homes, etc., while Part B, the Program involved in this litigation, provides supplementary medical insurance benefits, primarily for physician services.

15. Under Part B of the Medicare Program, individual patients who qualify pay a premium to the Federal Government for the medical insurance benefits. The premium is generally deducted from Social Security.

16. Physicians are reimbursed for treating Medicare recipients on the basis of their "reasonable charges". Reasonable charge is the lower of the charge the physician customarily charges for the same service and the prevailing charge in the community. See 42 U.S.C. 1395u. The prevailing charge may be defined as a 75th percentile for the same service by other physicians in the same locality.

17. From the time of its inception as a hospital and medical care corporation in the state of Michigan, until the commencement of the Federal Medicare Program, defendant BCBSM, under its private health insurance program, maintained a system of payment to physicians wherein the speciality of each individual physician, or absence thereof, had no bearing whatsoever on the amount of compensation to the pysician.

18. That 42 C.F.R. 405.504 provides that the carrier *may* in establishing the prevailing fees under the procedure referred to above draw distinctions between specialists and between specialists and non-specialists *only* where such distinction are in accordance with charge patterns.

19. That BCBSM, either on its own initiative, or at the direction of defendant HEW, devised a reimbursement system in Michigan, under the Medicare Program, of three separate "screens" for purposes of determining prevailing rates for physicians. These screens include one screen for internists, whether board certified, board eligible or non-board eligible, a separate screen for "other specialists", whether board certified, board eligible or non-board eligible, and a third screen which included non-physicians (such as podiatrists and chiropractors) and family physicians.

20. This decision to segregate family physicians from all other types of physicians for purposes of determining prevailing fees under the Medicare Program in Michigan, was not supported by actual differentials in charge patterns or charge levels of any of the groups referred to above.

21. That, in fact, no study of actual charge patterns or differentials was performed comparing various groups of physicians, i.e., differences between specialists, allopathic and osteopathic physicians, etc., by either defendant HEW or defendant BCBSM.

22. The effect of defendants' arbitrary segregation of family physicians from all other physicians has been to create artifical reimbursement levels, which generally reimburse family physicians at lesser amounts than all other physicians for performing the same services on behalf of Medicare recipients. This arbitrary discrimination has gone so far as to place family physicians into a category with podiatrists and chiropractors who are not physicians and whose education and training are not comparable to those of physicians.

23. In March, 1967 an Ad Hoc Committee of Blue Shield recommended that BCBSM should terminate its fixed fee schedule as a means of reimbursing physicians under its private insurance program and adopt the same discriminatory policy it utilized in its administration of the Medicare program. This policy was formally adopted on May 19, 1967 by BCBSM's Board of Directors which revised its private insurance program to provide for the three separate screens in determining prevailing fees.

24. That BCBSM's original basis for treating family physicians differently from all other specialists, both under its private insurance capacity and under the Medicare Program, were two 1966 directives of the Michigan State Medical Society. These directives, Resolution 16 and Resolution 36, simply incorporate the language of the Medicare Statute, providing no support for "A" and Exhibit "B" attached hereto.

25. In fact, neither the Medicare regulations nor the 1966 Michigan State Medical Society directives provide any hint whatsoever that family physicians are to be segregated from all other types of physicians for Medicare reimbursement, or for any other purpose.

26. In 1972 the Michigan State Medical Society clarified its position regarding these arbitrary dual fee principles BCBSM and HEW had created. This 1972 directive provided that there be no dual fee principle between family physicians and other physicians and adopted a definition of specialist which included family physicians. See Exhibits "C" and "D" attached hereto.

27. That defendant BCBSM refused to respond to this new directive from the Michigan State Medical Society for purposes of administering both its private insurance business and the Medicare Program. See Exhibit "E" attached hereto.

28. That at or near the same time, defendant BCBSM determined that a family physician who has passed a certifying examination of the American Board of Family Practice shall be classified as a "specialist", but a Board eligible family physician or non-board eligible family physician shall be treated as a "general practitioner" for Medicare purposes and shall be paid through the third screen as referred to previously.

29. That as modified by defendant BCBSM and defendant HEW, there are currently three separate reimbursement screens under the Medicare Program, which include one screen containing board certified and board eligible internists, one screen for "other specialists", including board certified family physicians, board certified other physicians, and board eligible other physicians, and a separate screen for board eligible family physicians, non-board eligible family physicians and various non-physician groups, such as podiartrists and chiropractors.

30. This maintenance of separate reimbursement screens has the effect of treating all board certified specialists and all board eligible specialists in any specialty other than family medicine as specialists in determining reimbursement but placing board eligible family physicians and non-board family physicians in a totally different category, essentially equating family physicians who are not board certified as non-physicians.

31. Since 1969, the American Board of Family Practice has passed standards for determining qualifications in the specialty of family practice. That pursuant to these requirements, a family physician will be considered "board eligible" if that family practitioner has undertaken approved residency programs in family practice or has been practicing the specialty of family practice for a number of years. Additionally, the American Board of Family Practice requires continuing medical education on an annual basis for either board certification or board eligibility.

32. That in order to qualify for membership in the Michigan Academy of Family Physicians one must maintain continued medical education in the amount of fifty hours per year. That under these standards, plaintiffs and all members of the Michigan Academy of Family Physicians have either completed approved residency programs or have the benefit of years of experience in primary practice, coupled with continuing medical education, a requirement unique to family physicians. The education and training of family physicians is at least equal to and possibly more extensive than that of many physicians in other specialties.

33. That under the Medicare Program, a physician may either accept assignment or look to the patient for direct payments.

34. That a physician accepting assignment is a physician who agrees to charge his patients no more than the rate determined by defendants.

35. That a physician who does not accept assignment has the option of charging for his services an amount in excess of the amount paid under the Medicare Program but must turn to the individual patients for payment for these services, the individual patient subsequently receiving reimbursement from defendant in the amount allowed pursuant to the screen.

36. That effective July 30, 1978 BCBSM instituted a statewide prevailing screen, eliminating all distinctions between physician specialties for purposes of determining reasonable charges. See Exhibit "F" attached hereto.

37. That despite the elimination of specialist/generalists differentials under BCBSM's private insurance program, defendants have steadfastly refused to eliminate such distinctions for purposes of determining reasonable charges under the Medicare Program, the Medicare Program being the only major insurance program in the state of Michigan, utilizing specialist/generalist distinctions for purposes of determining reasonable charges.

COUNT I

I. VIOLATION OF PLAINTIFFS' EQUAL PROTECTION AND SUBSTANTIVE DUE PROCESS RIGHTS UNDER THE FIFTH AMENDMENT.

38. Plaintiffs incorporate Paragraphs 1 thru 37 of their Complaint as if fully set forth herein.

39. Defendant BCBSM, while acting as intermediary or carrier under the Medicare Program, either in paying reimbursement claims or in determining prevailing fees, acts under color of Federal Law, thus, subjecting that organization to the due process and equal protection provisions contained in the Fifth Amendment to the United States Constitution.

40. Joseph Califano, as Secretary of the Department of Health, Education and Welfare, must administer the Medicare Program in a rational manner in order to comply with the due process guarantees of the Fifth Amendment of the United States Constitution, which has been held to incorporate the equal protection clause contained in the Fourteenth Amendment.

41. There are three recognized levels of health care, to wit: primary, secondary and tertiary. Family physicians are primarily involved in rendering primary care and are considered specialists in providing such services.

42. The practical impact of defendants BCBSM and HEW's creation and maintenance of the aforementioned separate screens is incongruent and creates the following irrational results:

(a) Plaintiff, Glenn W. House, M.D., as a board certified specialist in family practice, receives the same level of Medicare reimbursements in performing primary care procedures under the "screens" as a board certified or board eligible specialist who has less training and experience in the area of primary care while receiving less than board certified or board eligible specialists in internal medicine, whose training and experience is most similar to his own.

(b) Physicians in other specialties, in addition to performing secondary and tertiary health care services, for which they receive greater reimbursement than for primary care services, are performing in primary care services for which Dr. Charles Farber and Dr. Lester Webb, as family physicians, have equal or greater experience and training. Despite the equal or greater training and experience of plaintiffs Charles Farber, M.D. and Lester Webb, M.D. in the area of primary care, board eligible specialists who do not specialize in primary care receive greater reimbursement for primary care procedures.

(c) While separating family physicians from all other types of physicians for purposes of determining reasonable charges, family physicians are equated with podiatrists, chiropractors and other non-physicians, even though the training and experience of these non-physicians is in no way related to the training, experience and actual charge levels of plaintiffs.

(d) Medicare recipients who choose to be treated by family physicians and who pay the same premiums to the Federal Government for Medicare coverage receive less coverage by virtue of choosing a family physician to perform services than Medicare recipients who choose physicians of other specialties. The net effect of the Medicare reimbursement scheme is a direct economic loss to Medicare recipients treated by family physicians by virtue of the recipient's choice of physician for treatment.

(e) A board certified or board eligible physician in all fields except family practice is treated as a specialist for all services performed. For example, a general surgeon performing a pelvic examination is treated identically with a gynecologist for purposes of Medicare reimbursement.

(f) The reimbursement policy of defendants in administering the Medicare Program further aggravates the present shortage of primary care physicians, such as family physicians, which Congress has already characterized as an acute shortage. (See Health Profession's Educational Assistance Act of 1976, P.L. 94-484(HR 5546); October 12, 1976). This discriminatory treatment of plaintiffs by defendants is directly contrary to defendants' self-espoused objectives of cost containment.

43. That the treatment of family physicians differently from all other types of physicians for the performance of identical services constitutes a violation by defendants of plaintiffs' Fifth Amendment rights to equal protection and substantive due process.

44. Defendant BCBSM's and HEW's unconstitutional, arbitrary and capricious acts have created artificial rate discriminations which cause family physicians to be paid at a lower amount for performing identical services as other physicians, while being paid the same amount as non-physicians, such as podiatrists and chiropractors.

WHEREFORE, plaintiffs pray that this Honorable Court declare the maintenance of separate fee schedules by defendant Blue Cross and Blue Shield of Michigan, and by defendant, Joseph Califano, Secretary of Health, Education and Welfare, in administering the Medicare Program void and in violation of plaintiffs' equal protection and substantive due process rights and enjoin defendants from treating family physicians differently from other physicians for purposes of Medicare reimbursement.

COUNT II

VIOLATION OF PLAINTIFFS' PROCEDURAL DUE PROCESS RIGHTS UNDER THE FIFTH AMENDMENT.

45. Plaintiffs hereby incorporate Paragraphs 1 thru 44 of their Complaint as if fully set forth herein.

46. That on October 9, 1974 planitiffs requested a hearing with Defendant BCBSM, acting as carrier under HEW's Medicare Program, to provide plaintiffs with an opportunity to demonstrate that plaintiffs' training and experience was such as to warrant reimbursement equal to that received by other physicians. See Exhibits "G", "H", and "I" attached hereto.

47. That on December 6, 1974 defendant BCBSM indicated that plaintiffs may utilize a peer review procedure, but defendant BCBSM stated that the peer review officer's authority did not include the authority to make an adjudication regarding the reasonableness of the special/generalist fee differential, and that BCBSM would not accept any findings that would allow plaintiffs to be reimbursed amounts in excess of that allowed pursuant to the separate screen mechanism. See Exhibit "K" attached hereto.

48. By denying plaintiffs an opportunity to demonstrate that they have sufficiently qualified as family physicians to receive reimbursement equal to that currently being provided other physicians is to deny plaintiffs a hearing and creates an irrebuttable presumption that a family physician who performs a given medical procedure does not perform as valuable a service as other physicians performing the same service.

49. That the creation of such an irrebuttable presumption, based on the irrational determination that the service provided by family physicians are worth less than identical services performed by other physicians, is in violation of plaintiffs' procedural due process rights which are guaranteed by the Fifth Amendment to the United States Constitution, which would require defendants to provide plaintiffs notice and an opportunity for hearing prior to making such a presumption.

WHEREFORE, plaintiffs pray that this Honorable Court declare the maintenance of the three separate fee schedules by defendant and by defendant Joseph Califano, Secretary of Health, Education and Welfare, under the Medicare Program, void and in violation of plaintiffs' procedural due process rights and enjoin defendants from treating family physicians differently from other physicians under the Medicare Program.

COUNT III

VIOLATION OF MEDICARE STATUTE

50. Plaintiffs incorporate Paragraphs 1 thru 49 of their Complaint as if fully set forth herein.

51. Defendants BCBSM and HEW must comply with applicable Medicare statutes when performing its functions under the Medicare Program.

52. 42 U.S.C. 1345a guarantees a free choice by Medicare recipients of a physician under the Medicare Program.

53. Although plaintiffs' patients are equally eligible for benefits as other patients under the Medicare Program, and have paid premiums equal to that of other patients, plaintiffs' patients receive less coverage under said Program solely by virtue of choosing family physicians to perform covered services than do the patients of specialists.

54. Since these patients are directly responsible to the physician in cases of non-assignment of claim, the patients of plaintiffs suffer direct economic loss by virture of their choice of physician.

55. That the treating of family physicians differently from all other types of physicians and the lumping of family physicians with non-physicians constitutes a value judgment that the services of family physicians are not as valuable to the patient as services by other physicians, this judgment having no reasonable relationship to the administration of the Medicare Program and infringing directly upon the patient's choice of physician.

56. 42 U.S.C. 1395u(3)(E) simply provides that Medicare shall establish a prevailing charge ceiling equal to 75% of charges "for similar services in the same locality."

57. That there is no statutory authority granted to defendants to draw distinctions in payment between different types of specialty practice.

58. Defendants, in treating family physicians differently from all other types of physicians, are in direct contradiction of the Medicare statute, which bases the prevailing fee concept on similarity of service rather than any particular classification of the physician where identical services are performed.

WHEREFORE, plaintiffs pray that this Honorable Court Order that the maintenance of the separate fee schedules is in violation of the Medicare Act and enjoin defendants from treating family physicians different from other physicians in the administration of the Medicare Program.

COUNT IV

VIOLATION OF REGULATIONS

60. Plaintiffs incorporate Paragraphs 1 thru 59 of this Complaint as if fully set forth herein.

61. 42 C.F.R. 405.504(b) provides that Medicare carriers may establish separate prevailing charge screens for different types of physicians *only* where in accordance with actual charge patterns.

62. That, to date, defendants have failed to produce any data or other statistical evidence in support of the maintenance of separate screens within the state of Michigan.

WHEREFORE, plaintiffs pray that this Honorable Court declare the maintenance of separate fee schedules by defendants Blue Cross and Blue Shield of Michigan and Joseph Califano, Secretary of Health, Education and Welfare, in administering the Medicare Program, void and in violation of defendants' own promulgated regulations and enjoin defendants from treating family physicians differently from other physicians for purposes of Medicare reimbursement.

/s/ CHARLES FARBER, M.D.
CHARLES Farber, M.D.

/s/ GLENN W. HOUSE, M.D.
Glenn W. House, M.D.

/s/ LESTER WEBB, M.D.
Lester Webb, M.D.

STATE OF MICHIGAN) SS
COUNTY OF)

On this 20th day of March, 1979 before me personally appeared Charles Farber, M.D., who, being by me duly sworn, did depose and say that he has read the foregoing Complaint by him subscribed, that the same is true of his own knowledge, except as to those matters stated to be upon information and belief, and as to those matters, he believes it to be true.

/s/ CAROL J. TOWNSEND
Notary Public, [Kent] County, Michigan

My comm. expires: 10/13/79

STATE OF MICHIGAN) SS
COUNTY OF)

On this 10th day of April, 1979, before me personally appeared Glenn W. House, M.D., who, being by me duly sworn, did depose and say that he has read the foregoing Amended Complaint, by him subscribed, that the same is true of his own knowledge, except as to those matters stated to be upon information and belief, and as to those matters, he believes it to be true.

/s/ DELPHINE S. LEVESON
Notary Public, Oakland County, Michigan

My comm. expires: 1-11-82

STATE OF MICHIGAN) SS
COUNTY OF)

On this 15th day of March, 1979, before me personally appeared Lester Webb, M.D., who, being by me duly sworn, did depose and say that he has read the foregoing Amended Complaint, by him subscribed, that the same is true of his own knowledge, except as to those matters stated to be upon information and belief, and as to those matters, he believes it to be true.

/s/ DENNIS R. PRICING
Notary Public, Saginaw
County, Michigan

My comm. expires: [Illegible]

FRIMET, GOREN & BELLAMY, P.C.

By /S/ ALAN G. GILCHRIST
ALAN G. GILCHRIST
Attorneys for Plaintiffs
26600 Telegraph Road, Ste 310
Southfield, MI 48034
355-0022

Dated:

Exhibit A to the Amended Complaint

Resolution No. 16 of the House of Delegates of the Michigan State Medical Society (1966).

Definition of Customary, Prevailing and Reasonable Fee Introduced by George Reno, MD

Whereas, the Department of Health, Education and Welfare has accepted the concept of "customary, prevailing and reasonable fees" to physicians under Public Law 89-97, and

Whereas, these terms are not defined in the law, and

Whereas, the American Medical Association House of Delegates has deferred action on the matter until its Clinical Session in November, and

Whereas, the membership needs immediate guidance in the interpretation of these terms in billing for services under Public Law 89-97, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society hereby adopt the following definitions as approved in principle by the American Medical Association House of Delegates:

Customary relates to the individual physician and the charge which he most commonly establishes as fair recompense for specific services.

Prevailing relates to the range of usual charges made by physicians of similar ability and experience for the same service within the same specific socio-economic limited geographic area.

Reasonable: A fee is "reasonable" when it meets the "customary and prevailing" criteria or, in the opinion of a duly constituted medical society review committee, is justified under what is considered a complexity of treatment which merits special consideration, and be it be forwarded to Michigan Medical Service as fiscal agent of the Medicare program in Michigan.

THE REFERENCE COMMITTEE on Resolutions, Harold F. Falls, MD, Chairman, recommended approval of the resolution, amending the first Resolved to read as follows: "RESOLVED: That the House of Delegates of the MSMS hereby adopts the following definitions:
CUSTOMARY relates to the individual physician and the charge which he most commonly establishes as fair compensate for specific services.
PREVAILING relates to the range of usual charges made by physicians of similar ability and experience for the same service within the same specific socio-economic limited geographic area.
REASONABLE: A fee is "reasonable" when it meets the "customary and prevailing" criteria or, in the opinion of a duly constituted medical society committee, is justified under what is considered a complexity of treatment which merits special consideration, and be it further"

The HOUSE adopted the report of the Reference Committee.

Exhibit B to the Amended Complaint

Resolution No. 34 of the House of Delegates of the Michigan State Medical Society (1966).

Enactment of a Single Medical Practice Law
Introduced by John H. McLaughlin, MD

Whereas, the primary concern of Michigan doctors of medicine is the health needs of the people of Michigan, and

Whereas, this likewise is the primary concern of doctors of osteopathy, and

Whereas, the basic tenets of these two disciplines are essentially identical, and

Whereas, the present duplication of systems reduces the opportunity for attaining maximum standards of achievement in education, in research and ultimately in the care of the patient, therefore be it

RESOLVED: That the House of Delegates reaffirm its endorsement of a single medical practice act, and be it further

RESOLVED: That the Michigan State Medical Society promote legislation toward enactment of a single medical practice act.

THE REFERENCE COMMITTEE on Legislation and Public Relations, Philip K. Stevens, MD, Chairman, considered Resolutions 18 and 34 together.

For Reference Committee and House action, see Resolution 18.

Exhibit C to the Amended Complaint

Policy Statements of the Council of Michigan State Medical Society

Physician's fees

From 1965 to 1968 the MSMS Council made the following policy statements re Physician Fees:

* * * * *

The Council reaffirmed existing MSMS policy that there be no dual fee principle (between specialists and generalists) and that all reimbursements for service remain on a fee-for-service basis.
Council 66Apr/p46/3.

* * * * *

Exhibit D to the Amended Complaint

Policy Statement of the Michigan State Medical Society

SPECIALIST

Definition

MSMS has approved the following definition of a specialist:

"A specialist shall be a physician

1. certified by the appropriate specialty board, approved by the American Board for Medical Specialties and by the American Medical Association Council on Medical Education, or

2. practicing as a specialist not possessing a specialty board certificate, but has completed an approved residency in that specialty, or

3. is recognized as a specialist by the staff of the hospital in which he practices provided it is an accredited hospital, and is a physician who is eligible for certification by his specialty board."

Resolution No. 38 of the House of Delegates (1971).

Exhibit E to the Amended Complaint

Memorandum

For Information Only.

From February 9, 1972 minutes of
Consumer and Professional Relations
Committee of the Board of Directors.
[Blue Shield of Michigan]

IV. Definition of a Specialist:
Doctor Hayes described the background of this subject and the Committee was asked whether Blue Shield should adopt the 1971 MSMS House of Delegates Resolution #38, Definition of a Specialist, or an alternate definition proposed by management.

Discussion occurred regarding payments to different specialties, specialty Board eligibility and examinations, the new American Board of Family Practice, and the implications to Blue Shield of adopting either proposed change for MVF and Government Programs.

It was the consensus of the Committee that "specialists," in the traditional sense, should receive a higher level of payment than a specialist in Family Practice because there is a higher degree of training and skill in the traditional specialties.

MOTION was made, seconded and carried to recommend to the Board that Blue Shield retain the present definition of a specialist as adopted by the 1966 MSMS House of Delegates, with the understanding that management should study the feasibility of establishing a separate prevailing charge screen for the new specialty of Family Practice.

Exhibit F to the Amended Complaint

BLUE CROSS AND BLUE SHIELD OF MICHIGAN

JULY 26, 1978

GENERAL MEMO

Cancellation Date: September 26, 1978

TO: Supervisors and Above

SUBJECT: Statewide Prevailing Screens

Effective July 30, 1978 a statewide prevailing screen has been approved for payment of claims from all physicians by the Board of Directors of Blue Cross and Blue Shield of Michigan.

Since January of this year a statewide screen has been effective for participating physicians only. These physicians have been paid the lessor of the billed charge, the customary profile charge or the statewide prevailing screen. The non-participating physicians have been subject to the area/specialty prevailing screens.

The move to a statewide screen is the result of an agreement between Blue Cross and Blue Shield of Michigan and the Michigan State Medical Society. MSMS agreed to urge physicians to cooperate on the completion of the Michigan Medical Claim Form and to discontinue its efforts to seek physician departicipation. In return BCBSM is establishing a statewide screen for all physicians types in the state.

In addition to these points, all parties have selected representatives for a liaison committee to discuss the establishment of a prospective system to control aggregate payments for professional health care services and the development of an effective full service benefit by January 1, 1979. The effective date of the statewide screen for all physicians was contingent upon the agreement by the liaison committee of a plan of action and a timetable for implementation of the prospective reimbursement and the full service benefit. Details of both will be worked out in the next few months.

Any adjudication of claims priced prior to July 30 should continue to employ the area/specialty screens for non-par providers. The statewide screen is effective for claims priced beginning July 30, 1978.

Daniel J. Kehoe
Vice President
Provider Affairs

Exhibit G to the Amended Complaint

October 9, 1974

Mr. John McCabe, President
Michigan Medical Service
600 Lafayette East
Detroit, Michigan 48226

Re: Fee Discrimination

Dear Sir,

As a participating family physician with Michigan Medical Service, I do hereby request a hearing in order that Michigan Medical Service may present evidence and show cause why the charges Michigan Medical Service will pay me for my services as a physician are reasonable and non-discriminatory and to disclose the basis and criteria used by Michigan Medical Service to arrive at the payments made. It is my position that the fee schedules utilized by Michigan Medical Service are discriminatory towards me as a family physician. Since I believe Michigan Medical Service, as of this date, has no procedure for providing such a hearing, I suggest that the following are requisites for any such hearing:

1. That the hearing officer be a person independent of Michigan Medical Service.

2. That a written transcript be made of the hearing.

3. That the hearing officer be required to make written findings of fact and conclusions of law and that his decision be based solely on the record made by the parties before him.

4. That the petitioner be represented by counsel if he chooses.

5. That the petitioner's counsel be allowed to present written or oral evidence, cross-examine, witnesses, present oral or written argument, and in any other way represent his client and his client's interests before the hearing officer.

Mr. John McCable
October 9, 1974
Page #2

6. That the hearing officer should not be bound by formal rules of evidence.

7. That the hearing officer be furnished with no information regarding this matter by either party except when such material is simultaneously made available to the opposite party.

8. That the hearing should be open to the public and that said hearing be conducted in accordance with due process of law.

9. That the discovery, in the form of depositions, interrogatories, and requests for production of documents, be available prior to the hearing to me or my counsel with particular emphasis on the basis in which Michigan Medical Service determines the reasonable and customary charge for an individual physician.

If procedures for such a hearing already exist, please so advise me and indicate what the procedures are.

Your prompt reply would be much appreciated. Thank you.

Very truly yours,
/s/ CHARLES FARBER, M.D.

Charles Farber, M.D.

Exhibit H to the Amended Complaint

October 9, 1974

Mr. John McCabe, President
Michigan Medical Service
600 Lafayette East
Detroit, Michigan 48226

Re: Fee Discrimination

Dear Sir,

As a participating family physician with Michigan Medical Service, I do hereby request a hearing in order that Michigan Medical Service may present evidence and show cause why the charges Michigan Medical Service will pay me for my services as a physician are reasonable and non-discriminatory and to disclose the basis and criteria used by Michigan Medical Service to arrive at the payments made. It is my position that the fee schedules utilized by Michigan Medical Service are discriminatory towards me as a family physician. Since I believe Michigan Medical Service, as of this date, has no procedure for providing such a hearing, I suggest that the following are requisites for any such hearing:

1. That the hearing officer be a person independent of Michigan Medical Service.
2. That a written transcript be made of the hearing.
3. That the hearing officer be required to make written findings of fact and conclusions of law and that his decision be based solely on the record made by the parties before him.
4. That the petitioner be represented by counsel if he chooses.

5. That the petitioner's counsel be allowed to present written or oral evidence, cross-examine, witnesses, present oral or written argument, and in any other way represent his client and his client's interests before the hearing officer.

6. The the hearing officer should not be bound by formal rules of evidence.

7. That the hearing officer shall be furnished with no information regarding this matter by either party except when such material is simultaneously made available to the opposite party.

8. That the hearing should be open to the public and that said hearing be conducted in accordance with due process of law.

9. That the discovery, in the form of depositions, interrogatories, and requests for production of documents, be available prior to the hearing to me or my counsel with particular emphasis on the basis in which Michigan Medical Service determines the reasonable and customary charge for an individual physician.

If procedures for such a hearing already exist, please so advise me and indicate what the procedures are.

Your prompt reply would be much appreciated. Thank you.

Very truly yours,
/s/ LESTER WEBB, M.D.
Lester Webb, M.D.

Exhibit I to the Amended Complaint

October 9, 1974

Mr. John McCabe, President
Michigan Medical Service
600 Lafayette East
Detroit, Michigan

Re: Fee Discrimination

Dear Sir,

As a participating family physician with Michigan Medical Service, I do hereby request a hearing in order that Michigan Medical Service may present evidence and show cause why the charges Michigan Medical Service will pay me for my services as a physician are reasonable and non-discriminatory and to disclose the basis and criteria used by Michigan Medical Service to arrive at the payments made. It is my position that the fee schedules utilized by Michigan Medical Service are discriminatory towards me as a family physician. Since I believe Michigan Medical Service, as of this date, has no procedure for providing such a hearing, I suggest that the following are requisites for any such hearing:

1. That the hearing officer be a person independent of Michigan Medical Service.

2. That a written transcript be made of the hearing.

3. That the hearing officer be required to make written findings of fact and conclusions of law and that his decision be based solely on the record made by the parties before him.

4. That the petitioner be represented by counsel if he chooses.

5. That the petitoner's counsel be allowed to present written or oral evidence, cross-examine witnesses, present oral or written argument, and in any other way represent his client and his client's interests before the hearing officer.

6. That the hearing officer should not be bound by formal rules of evidence.

7. That the hearing officer shall be furnished with no information regarding this matter by either party except when such material is simultaneously made available to the opposite party.

8. That the hearing should be open to the public and that said hearing be conducted in accordance with due process of law.

9. That the discovery, in the form of depositions, interrogatories, and requests for production of documents, be available prior to the hearing to me or my counsel with particular emphasis on the basis in which Michigan Medical Service determines the reasonable and customary charge for an individual physician.

If procedures for such a hearing already exist, please so advise me and indicate what the procedures are.

Your prompt reply would be much appreciated. Thank you.

Very truly yours,
/s/ GLENN W. HOUSE, M.D.
Glenn W. House, M.D.

Exhibit K to the Amended Complaint

Blue Shield
of Michigan

Vice President –
Assistant to the President

600 Lafayette East
Detroit, Michigan 48226

December 6, 1974

Gilbert M. Frimet, Esq.
Frimet, Goren & Bellamy P.C.
26600 Telegraph Road - Suite 310
Southfield, Michigan 48076

Dear Mr. Frimet:

This is to acknowledge your letters of October 14 and November 27 concerning Dr House, October 18 and November 27 concerning Dr. Farber, and October 28 concerning Dr. Webb.

I am advised by Louis F. Hayes, M.D., our Senior Vice President for Medical Affairs, and Henry H. Sills, Esq., our General Counsel, that in addition to representing the above referenced individual physicians you are, or have been, the attorney for the Academy of Family Physicians and that there have been extensive discussions along the lines you now request.

I am also advised by Counsel that the appropriate forum, in which to present evidence or to show cause upon a physician's demand or request in such a matter is a proper Peer Review proceeding, to which this corporation is committed, or in litigation to which it may be subjected.

Rest assured, if you or any of your clients named above wish to discuss any problem they are encountering, you are welcome to do so at any time with our Medical Affairs Division, operation of which is Dr. Hayes' responsibility. Our personnel will do whatever they can to clear up any misunderstandings you or your clients may entertain.

Very truly yours,
/s/ BRIAN P. MACRAE
Brian P. MacRae

Blue Cross
Blue Shield
of Michigan

600 Lafayette East
Detroit, Michigan 48226

March 31, 1975

Mr. Gilbert M. Frimet, Esq.
Frimet, Goren & Bellamy, P.C.
26600 Telegraph Road, Suite 310
Southfield, Michigan 48076

Dear Mr. Frimet:

Thank you for your letter of March 19, 1975, with further inquiry on the matter of peer review for fee adjudication.

It is my impression that my February 13 letter did answer your question regarding representation by counsel at peer review hearings. Questions G, H and I, all dealing with the appearance of counsel, the rules of evidence and courtroom procedure (including cross-examination), were answered. The essence of the answer was that the presence of counsel, etc., was dependent upon the rules of each peer review committee. It would be appropriate for you to query each of the existing peer review committees about their rules.

Your March 19 letter has a misunderstanding about the test that we apply in the determination of a reasonable fee for a service. In the absence of unusual circumstances (individual consideration), we have but two "rules":

1. The payment will be no higher than the physician's customary charge for the service.

2. The payment will be no higher than the prevailing charge for similar services—by physicians of similar qualification—in the same socio-economic area.

I may have a misunderstanding as to what you meant by "discovery." When we submit claims to peer review committees for fee adjudication, we provide them with pertinent data regarding the range of charges for the service in question and the applicable area and specialist/generalist [illegible].

With regard to the "authority of peer review officers to resolve the controversy," I can only say that Blue Cross-Blue Shield of Michigan is committed to accept the peer review committee's adjudication on a disputed fee. In general, it is our perception that the physicians also abide by their adjudication. However, adjudications are to be provided within the framework of our payment mechanism, which is inclusive of area and specialist/generalist differentials. We would not accept an adjudication from a peer review committee that there should be no specialist/generalist differentials.

I remain,

Sincerely,
/s/ LOUIS F. HAYES, M.D.

Louis F. Hayes, M.D.
Group Vice President
Professional Affairs Division
Blue Cross and Blue Shield of Michigan

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

[Filed April 27, 1979]

No. 76-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS; A NON-PROFIT ASSOCIATION, CHARLES FARBER, M.D.; GLENN W. HOUSE,M.D., AND LESTER WEBB, M.D.,
PLAINTIFFS

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND JOSEPH CALIFANO, SECRETARY OF HEALTH, EDUCATION AND WELFARE,
DEFENDANTS.

JUDGE JULIAN COOK

ANSWER TO AMENDED COMPLAINT

NOW COMES the defendant JOSEPH CALIFANO, Secretary of Health, Education and Welfare, through his attorneys James K. Robinson, United States Attorney, and Samuel J. Behringer, Jr., Assistant United States Attorney, both for the Eastern District of Michigan. And comes defendant BLUE CROSS AND BLUE SHIELD OF MICHIGAN in its capacity as agent only for the Department of Health, Education and Welfare, through its attorney Ralph D. Gilpin. And in answer to the allegations of the plaintiffs' Amended Complaint states as follows:

FIRST DEFENSE

The Amended Complaint fails to state a claim upon which relief can be granted.

SECOND DEFENSE

The Court lacks jurisdiction over the subject matter of Count IX of this action.

THIRD DEFENSE

Answering specifically the numbered paragraphs of the plaintiffs' Amended Complaint, and utilizing the same paragraph numbering, the defendants state as follows:

1. Admits.

2-6. Admits on information and belief.

7. Defendants are without knowledge or information sufficient to form a belief as to the allegation.

8-9. Admits.

10. Admits.

11. Admits the allegations but denies the characterization of a "health insurer" and says the statutes cited in ¶ 10 designates BCBSM as a hospital, medical, surgical non-profit pre-paid plan.

12. Admits the allegations but denies the characterization of patients as "recipients" and says they are Social Security Act Beneficiaries.

13-15. Admits.

16. Denies the allegation as stated because it is inaccurate and incomplete. Further an essential element is missing, answered in ¶ 33, below.

17. Admits.

18. Denies the allegation as phrased because the context is altered. The correct citation of 42 CFR 405.504(b) carries a different connotation.

19. Admits the allegations but says they create an incomplete picture. Internists' screens are restricted to certain inpatient services only and the third screen described includes general practitioner physicians as well.

20. Denies on information and belief.

21. Admits but adds that accumulation of charge histories accomplished the purpose.

22. Denies the allegations as phrased. The paragraph omits mention of general practitioner physicians and declares podiatrists to be non-physicians. Podiatrists are physicians and surgeons within the meaning and scope of their licensure (OAG Mich 1961-62 No 4014) and therefore are physicians and surgeons within the meaning of § 1861(r) of Title 18 of the Medicare Act as interpreted by the Secretary.

23. Admits.

24. Admits the allegations but denies the characterization of "directives". By their terms, plaintiffs' Exhibits A and B are resolutions not binding as directives on BCBSM.

25. Denies because family physicians, as a distinctive group, did not exist as a specialty in 1966.

26. Denies the validity of plaintiffs' Exhibit C which is undated and untitled, and of the allegation it purports to support. Denies that Exhibit D makes any mention of family physicians.

27. Denies that BCBSM received any "directive" from the said Medical Society and says plaintiffs' Exhibit E speaks for itself.

28. Admits and says support is found in plaintiffs' Exhibit E. Further plaintiffs' reference to general practitioner conflicts with his allegation in ¶¶ 19 and 22.

29. Admits but incorporates defendants' answers to ¶¶ 19 and 22 here also.

30. Admits the general issue of ¶ 30 but denies that family physicians are "essentially equated" to non-physicians, because it is untrue.

31-32. Defendants are without knowledge or information sufficient to form a belief but notes that the former name of the Board was the American Association of General Practitioners.

33. Admits and says that assignment of right to payment is an essential element that does not enlarge physicians rights but only conveys whatever beneficiary right that may exist. It is in the nature of a quit-claim.

34. Admits and says that the restriction referred to is unseverable from the right to payment assignment.

35. Admits and says that a physician refusal to accept, or a beneficiary's refusal to grant, assignment estops the physician from assuming any standing to complain about the administration of the Medicare Act.

36. Admits but says it was a unilateral act applying to BCBSM private sector business only having no affect upon the Medicare program.

37.Admits the general issue of ¶ 37 but says that, on information and belief, Title 19 of the Social Security Act (Medicaid) also maintains dual screens on the same basis as Medicare, it being a major health insurance program in the state of Michigan.

COUNT I

38. No answer required.

39. Admits.

40. Admits the program must be administered in a rational manner but says constitutional construction does not hold that the Fifth Amendment incorporates the due process of the Fourteenth, the latter being binding on the several states.

41. Defendants are without sufficient information to make answer to the unsupported statement in ¶ 41.

42(a) Denies the allegation as a statement of fact. The situation alleged occurs only occasionally and the reverse may also occur on occasion depending upon the particular patient care factors involved.

42(b) Defendants are without information to know whether Drs. Farber and Webb are of "greater training or experience" than all other unnamed physicians, but believes it untrue and therefore denies. Further, Dr. Webb, by his own averment in ¶ 2, is not an assignee of any Medicare beneficiary and therefore has no standing to complain about reimbursement methodology.

42(c) Defendants deny the allegations because plaintiffs are not equated with non-physicians: podiatrists and chiropractors do not render family physician services and family physicians do not perform podiatry or chiropractic. Family physicians who are *not* board certified, are equated to general practitioner physicians, both M.D. and D.O. Otherwise, they are classed as specialists with all other specialists including internists.

42(d) Defendants deny the effect of the allegation pled: (1) Medicare beneficiaries do not all pay the same premium for their Title 18 coverage (§ 1839(d) of Title 18). (2) Physicians have no standing to complain as to the beneficiary's (not recipient's) choice of practitioner. That election runs to the beneficiary exclusively and is guaranteed by § 1802 of Title 10 of the Social Security Act (42 USC 1395a).

42(e) Admits but says plaintiffs' example is misleading. A gynecologist is often a surgeon and performs as such.

42(f) Defendants are without sufficient information to answer ¶ 42(f) and leaves plaintiff to his proofs.

43. Denies on the basis that plaintiffs have no contract with or membership in, Medicare and have no standing to complain except as they individually have accepted an affirmatively tendered assignment of benefits on an individual claim from an individual beneficiary. The plaintiff physicians stand in the shoes of the beneficiary and

the concomitant right to payment is no greater because of it. Further, because plaintiff DR. WEBB has not accepted any assignments he cannot complain of the reimbursement policy. And further, because plaintiff Academy performs no medical services for beneficiaries of Title 18, plaintiff Academy can receive no assignment of benefit payment and therefore has no standing to complain (see ¶ 5 of Amended Complaint).

44. Deny for the reasons stated throughout this Answer.

WHEREFORE, defendants move this court to dismiss LESTER WEBB, M.D. as a party plaintiff on the ground that he has no standing to complain on behalf of beneficiaries because he avers he accepts no assignment of benefits from beneficiaries and is not a provider with an agreement with the Secretary under § 1866 of Title 18 of the Social Security Act. Defendants further move this court to dismiss Michigan Academy of Family Physicians on the ground that it is not a provider of services or a physician within the meaning of Title 18 and provides no medical services to any beneficiary nor is eligible to receive any payment by assignment or otherwise. Defendants further ask this court to dismiss Count I as not having made out a cause of action.

COUNT II

45. No answer required.

46. Defendants deny the validity of ¶ 46 and of plaintiffs' Exhibits G, H and I. There is no basis for such a claimed hearing right under state or federal law. Further, all three exhibit-letters are identical; they make no mention of Medicare; they relate *only* to BCBSM's private sector business which is not a basis for this Amended Complaint. Exhibit H states that LESTER WEBB, M.D. is a participating physician, whereas in ¶ 56 of plaintiffs' original verified complaint, LESTER WEBB, M.D. declared he *is not* a participating physician in the private sector.

47. Admits but says plaintiffs' Exhibit K (and Exhibit J for which there is no allegation reference) discusses private sector business only and does not incorporate any reference to or interpretation of any rule or regulation of the Secretary.

48. Defendants deny the allegation of ¶ 48 and say that there is no support for application of these averments to the Medicare program. Further if any such complaint exists, plaintiffs are barred by the Federal Tort Claims Act for failure to exhaust administrative remedies (28 USC § 2401(b)). Plaintiffs' exhibit-letters are not applications for relief to a federal officer charged with administration of Medicare.

49. Defendants deny that any irrebuttable or irrational presumptions were made but in any case, the determinations complained of in this Count II have no application to the medicare program.

WHEREFORE, defendants move this court under Rule 12(c) FRCvP for judgment on the pleadings dismissing Count II. There is no federal question presented and no pendant jurisdiction on any state claim or cause of action, none having been alleged.

COUNT III

50. No answer required.

51. Admits.

52. Admits the essence of the allegation but says Title 42 of the U.S. Code does not have a § 1345a.

53. Denies that any such result obtains from the use of family physicians. "Coverage" relates to services, not payment and is found in § 1832 *et seq.* of the Act and is available to all equally (styled Scope of Benefits). Further, Medicare beneficiaries are not recipients, and do not all pay the same premium (§ 1839(d) of Title 18). Further, plaintiffs have no standing to complain as to the rights or

disabilities of any Medicare beneficiary.

54. Denies the validity of the allegation. In non-assignment claims, plaintiffs acquire no rights to Medicare benefits whatsoever. Plaintiffs' patients have chosen their physician by free will (42 USC 1395a) and any debt created between them is not a liability over to the defendants.

55. Denies the essence of the allegation. Not all family physicians are classified as non-specialists nor are they "lumped" with non-physicians. The classifying complained of was established for good and sufficient reasons. Further, the plaintiffs are not surrogates of beneficiaries and cannot be heard to complain about how patients choose physicians.

56. Admits but says the 75% referred to in § 1395u(3) cannot be described as "simply".

57. Denies. The Act provides that charges shall be reasonable and authorizes the Secretary to promulgate rules of interpretation (§ 1871 of the Act). Plaintiffs acknowledge this fact as true in ¶61 of their Amended Complaint.

58. Denies the allegation and says it is in direct conflict with ¶61 of the Amended Complaint. Defendants incorporate their answer to ¶56 herein.

WHEREFORE, defendants pray this court to find that the administration of the Medicare program is in conformance with the controlling statutes and regulations. Further defendants move this court under Rule 12(c) FRCvP to dismiss Michigan Academy of Family Physicians as a party plaintiff on the ground that it is not a provider of services or a physician as recognized by the Act. Further defendants move the court to find that the three plaintiff doctors are not surrogates of beneficiaries and do not have standing to complain of the manner in which beneficiaries choose physicians. Further, defendants move to dismiss DR. WEBB as a party plaintiff on the additional ground that he is not an assignee of any beneficiary's right to Medicare payment and therefore has

no standing to complain as to the method of reimbursement by his own admission in ¶2 of the Amended Complaint.

COUNT IV

60. No answer required.

61. Denies the interpretation of the cited regulation. It provides for establishment of differentials in the level of charges between physicians who engage in different specialty practices, according to charge patterns.

62. Denies. Discovery to date has disclosed data and statistics supporting different screens. Further, current Medicare reasonable charge screens, in the possession of plaintiffs, show that differences in payment levels between specialists and non-specialists are equal in a great many procedures and, in some, that for non-specialists is a higher level.

WHEREFORE, defendants pray this action be dismissed and that the court grant such other and further relief as may be appropriate. Defendants incorporate their ad damnum clause to Count I herein.

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Dated:

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 6-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, A NON-PROFIT ASSOCIATION, CHARLES FARBER, M.D., GLENN W. HOUSE, M.D., AND LESTER WEBB, M.D., AND CAROL A. DIEDRICH,
PLAINTIFFS,

VS.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, AND PATRICIA HARRIS, SECRETARY OF HEALTH, EDUCATION AND WELFARE,
DEFENDANTS.

ALAN G. GILCHRIST – P23408
ATTORNEY FOR PLAINTIFFS

JAMES R. LITES – P29265
ATTORNEY FOR PLAINTIFFS

MICHELE COLEMAN MAYES – P25058
ATTORNEY FOR DEFENDANT HEW

RALPH D. GILPIN – P26273
ATTORNEY FOR DEFENDANT BCBSM

SECOND AMENDED COMPLAINT

NOW COME the plaintiffs, Michigan Academy of Family Physicians, a Non-Profit Association, Charles Farber, M.D., Glenn W. House, M.D., Lester Webb, M.D., and Carol A. Diedrich, by their Attorneys, FRIMET, BELLAMY, GILCHRIST & JEHLE, P.C., and for their Second Amended Complaint state as follows:

37a. Plaintiffs hereby incorporate paragraphs 1 through 63 of their Amended Complaint as if those paragraphs were fully set forth herein.

37b. Plaintiff Carol A. Diedrich is a resident of the City of Okemos, State of Michigan and is a Medicare recipient.

37c. Plaintiff Carol A. Diedrich's physician is Phillip Lange, M.D., a family physician who is a member in good standing of the Plaintiff Michigan Academy of Family Physicians and who is not Board certified in family practice.

37d. Phillip Lange, M.D. does not accept assignment for services performed on behalf of Medicare recipients.

37e. As a result of her choice of Dr. Phillip Lange as her physician, Plaintiff Carol A. Diedrich receives less health care medical coverage under the Medicare program than similarly situated Medicare recipients who receive similar medical services even though Plaintiff Carol A. Diedrich pays the same premium for Medicare coverage as all other Medicare recipients.

WHEREFORE, Plaintiff prays that this Honorable Court declare the maintenance of separate fee schedules by Defendants Blue Cross and Blue Shield of Michigan and Joseph Califano, Secretary of Health, Education and Welfare, in administering the Medicare Program, void and in violation of Defendant's own promulgated regulations, the Medicare Statute, the Fifth Amendment to the United States Constitution and that this Honorable Court further enjoin Defendants from treating family physicians differently from other physicians for purposes of Medicare reimbursement.

FRIMET, BELLAMY,
GILCHRIST & JEHLE, P.C.

/s/ JAMES R. LITES

James R. Lites
Attorney for Plaintiff

/s/ ALAN G. GILCHRIST

Alan G. Gilchrist
Attorney for Plaintiff

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 6-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS,
A NON-PROFIT ASSOCIATION,
CHARLES FARBER, M.D.,
GLENN W. HOUSE, M.D., AND
LESTER WEBB, M.D.,
PLAINTIFFS

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
SECRETARY OF HEALTH, EDUCATION
AND WELFARE,
DEFENDANTS.

JUDGE JULIAN A. COOK
Filed May 2, 1980

DEFENDANTS' ANSWER TO PLAINTIFFS' SECOND AMENDED COMPLAINT

Defendants, the Secretary of Health, Education and Welfare and Blue Cross and Blue Shield of Michigan, in its capacity as the Secretary's agent under the Medicare Act, by and through their attorney, James K. Robinson, United States Attorney for the Eastern District of Michigan, Michele Coleman Mayes, Assistant United States Attorney, of counsel, in response to plaintiffs' second amended complaint pleads as follows:

FIRST DEFENSE

The second amended complaint fails to state a claim upon which relief can be granted.

SECOND DEFENSE

The Court lacks jurisdiction over the subject matter of this action.

THIRD DEFENSE

Answering specifically the numbered paragraphs of plaintiffs' second amended complaint, defendants plead as follows:

37a. Defendants hereby incorporate by reference their answers to paragraphs one (1) through sixty-three (63) to plaintiffs' [first] amended complaint as though they were fully set forth herein.

37b. In response to paragraph 37b, defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations contained herein.

37c. In response to paragraph 37c, defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations contained therein.

37d. In response to paragraph 37d, defendants are without knowledge or information sufficient to form a belief as to the truth of the allegation contained therein.

37e. Answering paragraph 37e, defendants deny the allegations contained therein.

Defendants hereby specifically deny all allegations of the second amended complaint not hereinbefore otherwise answered.

WHEREFORE, having fully answered, defendants pray that this action be dismissed and that the Court grant such other and further relief as may be appropriate.

Respectfully submitted,
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United States Attorney

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Dated: Detroit, Michigan
May 1, 1980

In the Supreme Court of the United States

No. 85-225

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

ORDER ALLOWING CERTIORARI. Filed October 7, 1985.

The petition herein for a writ of certiorari to the United States Court of Appeals for the Sixth Circuit is granted.